Application for Medical Student Clinical Elective Rotation

Legacy Emanuel Medical Center (LEMC)
2801 N Gantenbein Ave – Portland, OR 97227

Legacy Good Samaritan Medical Center (LGSMC)
1015 NW 22nd Ave – Portland, OR 97210

APPLICANT INFORMATION

(Gender and SSN needed for access to hospital medical records)

Name: (last)_____(first)_____(MI)___Home Telephone:_____

Mailing Address:_____

Gender: M__F___ Date of Birth:_____Social Security No:_____Email Address: _____

Emergency Notification:_____Telephone: _____

Medical School:_____Anticipated Graduation Date:_____

What is your future specialty?_____

Have you rotated here before? Yes or No If yes, which Facility: LEHHC LGSH LMPH LMHMC LSCH

Clinical Rotation/ Location Requested	Requested Dates 1st Choice		Requested Dates 2nd Choice	
	Start	End	Start	End
1.				
2.				

INSTITUTIONAL INFORMATION

This section to be completed by applicant's Dean or Registrar

		Circle One	
1.	This medical student is currently enrolled and in good standing at the institution, and has completed a criminal background check meeting minimum criteria for admission to the institution.	Yes	No
2.	This medical student is covered by professional malpractice insurance for a minimum of $1 million per occurrence and $3 million aggregate at all times while the student is participating in the clinical rotation valid in the State of Oregon.	Yes	No
3.	This medical student has major medical insurance, valid at all times while Student is participating in the clinical rotation, to cover any injury or illness arising there from valid in the State of Oregon.	Yes	No
4.	This student has completed the following immunizations: Rubeola, Rubella, Mumps and Varicella. Verification of Tuberculin status and Hepatitis B status.	Yes	No
5.	This medical student is a U.S. citizen or has an appropriate U.S. visa.	Yes	No
6.	The medical student has valid CPR certification while participating in this clinical rotation.	Yes	No

This above named student is qualified to take this clinical elective rotation, and is hereby authorized to take the requested clinical elective rotation at Legacy Health System.

X_____

Signature of Institutional Representative (Dean or Registrar) Date

_____

Please print name, title and telephone number of institutional official completing this form

Institution Name and Address:_____

Approval - To be completed by Legacy Health official

Elective Rotation	Approval		Dates	Signature
	Yes	No		
1.				
2.				

PLEASE RETURN COMPLETED FORM TO:

Traci Aul, G.M.E. Dept. c/o Legacy Good Samaritan Medical Center
1015 NW 22nd Ave, Northrup Bldg. Suite 22, Portland, OR 97210
Fax: 503-413-7361. Phone: 503-413-7590

Last updated 7/20/09